ILLINOIS EXCHANGE GUIDE

Introduction

This booklet provides policymakers and interested parties with a framework to help plan for and establish an Illinois-based Exchange. While this booklet can help develop a roadmap to implementation, it will need to monitor and participate in the many policy and regulatory decisions to be issued by the federal government. As federal policies are established and regulations are promulgated, we will need to adapt and modify our plan in order to successfully establish an Illinois Exchange.

Establishing an Illinois Exchange

An immediate decision for Illinois is whether to establish its own Exchange or to rely on the federal government to do so. While deferring this responsibility to the federal government may seem appealing, there are pros and cons for us to consider. Some of the reasons for Illinois to establish its own Exchange are:

- Maintaining regulatory authority over a large share of the commercial health insurance market;
- Mitigating risk selection that may result from different rating and underwriting rules for insurance policies sold inside and outside the Exchange;
- Enabling greater coordination of benefits and eligibility rules across health coverage programs (e.g., Medicaid and CHIP)

On the other hand, there are risks for Illinois choosing to establish its own Exchange, including:

- The challenge of creating a new program, particularly at a time when Illinois is struggling to balance its budget;
- The requirement that the Exchange be self-sustaining by 2015; and
- The tension that will be created between keeping administrative fees low while satisfying the demands for high quality customer service

In addition to some of the funding and policy issues, regulatory issues must also be addressed.

A federally administered Exchange that operates alongside a state-regulated health insurance market could lead to risk selection issues if the rating and/or underwriting rules are not the same. For example, if small employers purchasing coverage through the Exchange must meet participation requirements (i.e., percentage of employees that are covered by the policy) that differ from the participation requirements for small employers

purchasing coverage outside the Exchange, carriers operating inside the Exchange may be advantaged or disadvantaged.

Regardless of who runs the Exchange, rating rules and underwriting requirements to mitigate risk selection inside and outside the Exchange will need to be addressed. An Exchange administered by the federal government, operating alongside a state-regulated individual and small group market, will only increase the likelihood of inconsistent rules between the two markets. An Illinois administered Exchange will likely be better positioned to align the rules and regulations across all distribution channels to avoid, or at least minimize, the potential for risk selection.

Other issues for Illinois to consider in deciding whether to establish an Exchange is the number of carriers operating in the market, the potential to increase carrier competition, and the ability to promote greater transparency about cost and quality. The dominance of a single insurer in some markets has been offered as a reason why an Exchange may not be appropriate for all states. With only one carrier operating in the market, there may be little that an Exchange can do to affect the health insurance market.

However, several additional factors are worth considering. First, the availability of premium subsidies for millions of individuals across the country – including tens of thousands of people in states with relatively small populations – will alter the competitive landscape and should result in new entrants, particularly in markets that have been dominated by one or two insurers. Illinois should evaluate the potential to improve competition with the introduction of an Exchange and consider the role the Exchange may play in promoting greater transparency of health plan pricing, policies, and performance.

Additionally, the availability of federal funds to establish nonprofit, member-run health insurance plans (i.e., Consumer Operated and Oriented Plans, or CO-OPs) may provide an opportunity to improve competition in those markets that have limited carrier participation. By overseeing and operating an Exchange, Illinois will be able to ensure a level playing field for all carriers, including CO-OPs and new market entrants.

Establishing an Illinois Exchange will carry both risk and reward. A successful Exchange that efficiently and cost-effectively connects people with health insurance can be a powerful force. State officials, as well as health insurers, consumers, advocates, employers, providers, and other stakeholders, are rightfully concerned about how this new entity will fit into their existing markets. Allowing the federal government to operate the Exchange is clearly an option for Illinois to consider. But in making that decision, Illinois will need to carefully weigh the advantages and disadvantages.

Structure

If Illinois decides to run its own Exchange, the governance and administration of the Exchange are among the most important initial decisions. At its core, an Exchange is a distribution channel for commercial health insurance. Under federal health reform, Exchanges are also conduits for premium subsidies and reduced cost sharing, thereby enabling individuals and small employers to purchase insurance.

The ACA provides Illinois with latitude in establishing a governance structure for the Exchange. We could operate the Exchange like any other state program and designate an executive agency to run the Exchange. Under this approach, our state's secretary of health and human services or commissioner of insurance, for example, might be responsible for oversight and management of the Exchange. An advisory board might be established to provide input and offer advice on Exchange policies and procedures, but the ultimate decision-making authority would rest with an executive branch agency.

An alternative approach, and the one I recommend, is for Illinois to establish a governing body that is separate and apart from state agencies to serve as the policy-making body for the Exchange.

Because the Exchange will need to be in-sync with the activities of a number of other state agencies – particularly Illinois' insurance regulator and its Medicaid agency – the Exchange's governing board might include state officials with expertise in those areas.

Board representation from organizations with experience in the individual and/or small group markets could also be useful, providing the governing board with insight into those markets and firsthand knowledge of the types of plans consumers have selected in the past and the way those markets operate. Because the individual and small group markets operate under different rules than the large group market, we would be well served to include an individual with experience in those markets on the Exchange board.

The availability of subsidized coverage for individuals and families with income up to 400 percent FPL will likely drive millions of people to purchase coverage through the Exchange. Small employers with lower-income workers may also be eligible for premium subsidies for insurance purchased via the Exchange. However, small employers' premium subsidies will be limited to two years in duration.

Though premium subsidies may induce tens of thousands of small employers to purchase health insurance through the Exchange, it is likely that individual purchasers will comprise the largest share of the Exchange's market. A further complicating factor with the Exchange is that group coverage purchased through the Exchange may require a shift from composite rating, the practice in most markets, to list-bill rating.

Under composite rating, a group's premiums for each rate basis type (i.e., individual, two-person, family) are based on the membership of the group as a whole. For each rate basis type, all members of the group are charged the same premium. In contrast, under list-bill

rating, premiums for each member of the group will differ based on the member's age and the health plan selected.

This will add a level of complexity that may affect the Exchanges' ability to attract employers. In Massachusetts, administering the small employer program has proven challenging, and participation by small employers in the Massachusetts Connector, to date, is extremely limited.

Exchange administrators will need to simplify the shopping experience for employers, and their employees, in order to attract sufficient volume.

Administration

The law requires that the Exchange be administered by a governmental agency or non-profit entity established by the state, providing some flexibility for states to decide whether to house the Exchange within an existing governmental agency; in a new agency or quasi-public authority; or at a non-profit entity.

Three existing state agencies may be generally considered as "obvious" for the Exchange: 1) insurance departments; 2) Medicaid agencies; and 3) state employees' health benefits administrators. In addition, Utah currently houses its Exchange in the governor's office of economic development. There are pros and cons to each of these agencies serving as Exchange administrators.

The high-profile nature of the Exchange and its wide range of responsibilities suggest that the administration of an Exchange might best be placed in the hands of a new agency, a quasi-public authority, or a nonprofit entity established for the express purpose of operating the Exchange. The recommended approach is to designate or create an entity that is solely devoted to the establishment and operation of the Exchange, overseen by a governing body responsible for setting policies and procedures.

While federal grants will be available from late 2010 through 2014 to support the planning, establishment and initial operations of the Exchange, federal grants cannot be renewed beyond December 31, 2014 (one year after the Exchange is operating), and the Exchange will need to be self-financed in 2015 and beyond. The Exchange will likely need to generate operating revenues through retention of a portion of premiums or through direct payments from the participating carriers. Direct payment is recommended

The financing required to operate the Exchange will depend on a number of factors, including, but not limited to:

- The need to establish interfaces between the Exchange and health insurers for functions such as rate development, transfer of enrollment information, and eligibility for premium subsidies;
- The manner by which eligibility for premium subsidies will be processed;

- The ability of the Exchange to leverage existing infrastructure for its operations:
- Whether the Exchange will handle premium billing, collection and reconciliation;
- The extent of outreach and marketing undertaken by the Exchange;
- The development and maintenance of a website that is capable of providing decision-support tools used by consumers to evaluate their health insurance options;
- The level and type of reporting required by the federal government.

How these and other issues are handled, along with an estimate of the number of people served by the Exchange, will determine the revenues needed to support the operations. There will be tension between keeping administrative fees as low as possible and providing consumers with high quality service.

Developing a Plan

Having established a governance structure and administrator for the Exchange, a critical step will be the development of a plan and timeline for implementation. The plan will identify the services that need to be in place, along with a roadmap to get there, to meet the January 2014 deadline.

A key ingredient in the development of the strategic plan will be a thorough understanding of the current market, including documenting the potential population to be served by the Exchange. Assembling a strong foundation of knowledge and data will enable the Exchange board, staff, and state policymakers to structure an Exchange that best meets Illinois' needs.

A comprehensive understanding of our current health insurance market should include not only an examination of the uninsured, but also an examination of the insured, recognizing that people move in and out of health coverage, as well as across different types of coverage (i.e., public and private), throughout the year.

The analysis of the uninsured should include:

- Estimates of the total number of uninsured;
- Demographic information, as well as geographic/regional variations;
- Family income status;
- Employment, including a breakdown of the uninsured who are employed; and
- Eligibility for existing publicly subsidized health coverage programs.

This information is useful for a number of reasons, not least of which is the value in helping to quantify the number of people who do not have access to health coverage, and

developing projections of the potential pool of people who may be covered through the Exchange.

A second phase of the analysis should include a review of existing publicly subsidized health insurance programs, including the penetration of the different programs, the distribution methods for each program, and a review of how existing programs may complement or compete with coverage that will be offered through the Exchange.

The final phase of the analysis should include a review of the commercially insured, in much the same way that the examination of the uninsured was undertaken.

The review of the insured population should include the following:

- A demographic profile of the insured across each of the major market segments (i.e., individual, small group, large group);
- Geographic/regional variations in the coverage rate of the commercially insured;
- The number of carriers operating in the market:
- A breakdown by size of employers that offer insurance;
- Types of insurance provided by employers (i.e. benefit design, cost sharing arrangements);
- Premiums and percentage paid by employees and employers;
- Employees' rate of employer-sponsored insurance by size of employer; and
- The manner in which individuals obtain coverage (i.e. directly from carriers, through a broker, using an intermediary, etc.)

Particular attention should be paid to the individual and small group markets.

This will help on a number of fronts, particularly with regard to key policy decisions that will need to be made to effectively shift the individual and small group markets from one in which insurers "compete" by avoiding risk through the use of medical underwriting to a market in which insurers compete based on price and quality.

These changes in the rating rules will mean that individuals and small employers who are currently unable to purchase insurance or who are effectively priced out of the market due to health status may be able to purchase coverage. On the other hand, it will also mean that individuals and small employers who have coverage today may see their premiums adversely affected by the addition to the risk pool of people who had previously been denied coverage due to their medical conditions.

The law recognizes that in most states these changes to the individual and small group market rules will result in risk selection problems for insurers. To mitigate this impact, the health care reform law includes three mechanisms to address risk selection and provide some financial protection for insurers:

- Transitional reinsurance program for the individual market in each state;
- Risk corridors in the individual and small group markets; and
- Risk adjustment to transfer funds among health plans that offer coverage in the individual and small group markets based on the relative health status of their enrollees

While these provisions of the health care reform law are designed to address the risk selection problems that may result from the switch to a guaranteed issue, modified community rating system, the data and information collected as part of the background research effort can be used to develop actuarial and economic models to help policymakers as they grapple with a number of key questions.

The analysis from this research effort will be helpful to the Exchange, as well as beneficial to state policymakers and regulators who will be implementing changes to the state's individual and small group markets. Using the information from each phase of the analysis will help with the development of a strategic plan for the Exchange, which can be used to determine:

- How the Exchange will interact with the state's Medicaid/CHIP program and how the Exchange will fit into other publicly subsidized health coverage programs;
- The Exchange's business plan and financial model to become self-sustaining;
- The targeted outreach and marketing efforts that will be necessary to attract a broad and diverse risk pool;
- The role of the Exchange in the commercial health insurance market, and whether the Exchange will be proactive in encouraging carriers to develop and offer innovative plan designs; and
- Whether, and how, the Exchange will be used to support broader policy initiatives such as payment reform, service delivery reform, or other health care and health insurance reforms Illinois may be pursuing.

The strategic plan may also establish whether the Exchange will be an active or passive player in the market. The Exchange may be an agent of change or it may play a more limited role as a basic distribution channel for commercial insurance and premium subsidies for low and moderate income individuals and families.

Exchange Responsibilities

The Exchange is a market organizer, distribution channel for commercial insurance, conduit for premium subsidies and reduced cost-sharing, and enforcement arm for compliance. At its core, the Exchange must attract and retain customers by offering quality health insurance plans offered by qualified health insurers. Thus, it must process transactions effectively and efficiently; provide members with information to make informed decisions; establish a streamlined eligibility and enrollment process; and administer a process to enable individuals to apply for waivers from the health insurance mandate.

Federal law expects states to use a:

> "single, streamlined form that: may be used [by individuals] to apply for all applicable state health subsidy programs, within the state; may be filed online, in person, by mail, or by telephone; may be filed with an Exchange or with state officials operating one of the other applicable state health subsidy programs; and is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable state health subsidy programs."

Illinois is expected to establish a single portal – potentially feeding into a single eligibility engine – that will be used to determine eligibility for Medicaid, CHIP, the Exchange, and other state health insurance programs with separate Medicaid and CHIP programs that operate under different eligibility rules and that process applications through different eligibility engines, establishing a single portal/single eligibility engine may require a significant upgrade to existing eligibility systems or the development of a new eligibility system to process applications and determine eligibility.

The vision for the Exchange, and other public health coverage programs, is that an individual will be able to provide a limited amount of information and find out whether he/she is eligible under any of the health coverage programs available in Illinois.

However, eligibility for coverage and premium subsidies through the Exchange will be predicated on whether the applicant has access to employer-sponsored insurance (ESI), whether the ESI meets actuarial standards and provides "minimum essential benefits," and whether the employee's share of the premium as a percentage of his/her income is above or below a certain percentage of his/her income. In addition, only legal residents will be allowed to purchase coverage through the Exchange, regardless of their eligibility for premium subsidies.

The federal government will be issuing regulations regarding the single portal eligibility system and the standard eligibility form. However, Illinois will need to start planning for the development of a system that can process applications and determine eligibility for all health coverage programs.

Federal law requires that Exchanges offer only "qualified" health insurance plans that provide coverage for "minimum essential benefits." What "qualified" and "minimum essential benefits" mean will be determined by the secretary of HHS. However, Illinois may

require plans to cover benefits beyond the minimums established by the federal government, but the cost of those additional benefits must be borne by us. This may mean that our mandated benefits that are not considered "minimum essential benefits" will be responsible for paying, on behalf of enrollees receiving premium subsidies through the Exchange, for the additional premium amount associated with the cost of those benefits.

In addition to the potential cost to Illinois with mandates or requirements that go beyond the federal government's "minimum essential benefits," the administrative challenge of adjusting premiums and paying health carriers separately for the cost of those additional benefits could be a significant administrative and operational burden. We will need to review carefully the federal regulations that establish "minimum essential benefits" and compare those benefits to their list of mandates and benefit requirements.

Benefit Levels: Health plans offered through the Exchange will be available in five benefit levels: Platinum, Gold, Silver, Bronze, and Catastrophic. The benefit levels will vary based on "actuarial value," which is a measure of the amount of medical claims that would be paid by the health plan as a percentage of the total medical claims incurred for a standard population. In essence, the different benefit levels will have different amounts of cost sharing.

Platinum plans will cover 90 percent of the cost of care. This means that a member enrolled in a Platinum level plan would, on average, pay ten percent of the cost of care through co-payments, co-insurance and/or other types of cost sharing. The actual amount of cost sharing will vary for each member, based on their use of services and supplies.

A health plan with an actuarial value of 90 percent has relatively modest cost sharing. For example, the Platinum plans might have no upfront deductible; office visit co-payments of $20; inpatient hospitalization co-payments of $250 per admission; outpatient surgery co-payments of $50 per procedure; and prescription drug co-payments of $10/$25/$50 for generic, preferred brand-name, and non-preferred brand-name drugs, respectively.

Gold plans will cover 80 percent, Silver plans will cover 70 percent, and Bronze plans will cover 60 percent. Catastrophic plans, which are limited to individuals younger than 30 or people who are exempt from the insurance mandate due to affordability or other hardship, will be high deductible health plans (HDHPs).

While standardizing benefits may be desirable from the perspective of helping consumers navigate what can be a confusing process, being overly prescriptive may result in products that are out of sync with the market. The depth and breadth by which benefits are standardized will be an important decision for our policymakers and the Exchange.

Basic Health Program: The health reform law provides states with an option to create a "Basic Health Program" for individuals with income between 133 and 200 percent FPL, in lieu of their receiving coverage through the Exchange. This Basic Health Program must offer, at a minimum, the same level of benefits and limits on cost-sharing that individuals would have received had they purchased a Platinum level plan (for individuals with income up to 150 percent FPL) or a Gold level plan (for individuals with income between 150 and

200 percent FPL). However, the monthly member premium for the Basic Health Program cannot exceed the monthly premium that the eligible individual would have been required to pay if he/she had enrolled in the second lowest cost Silver level plan available through the Exchange.

If we opt for the Basic Health Program, Illinois will be required to establish a competitive procurement process, including negotiating premiums and cost sharing with the health insurers; and, "to the maximum extent feasible," states will need to make available multiple health plans to eligible individuals covered under the Basic Health Program.

However, Illinois will need to consider not only whether it may be able to offer individuals in this income category a richer health benefit package for less, but the potential impact to the commercial insurance market that may result from separating those individuals from the rest of the risk pool. Individuals eligible for the Basic Health Program will not be eligible for premium subsidies and reduced cost sharing through the Exchange.

It is likely that individuals with income between 133 percent and 200 percent FPL will constitute a sizeable proportion of the uninsured who will be eligible for premium subsidies for commercial insurance through the Exchange. Roughly 25 to 30 percent of the uninsured in every state have income between 100 percent and 200 percent FPL. Removing that group from the individual commercial market and separating them from the Exchange may have a number of consequences.

Carrier and Plan Selection

Because the Exchange will offer low and moderate income individuals federally funded premium subsidies and reduced cost-sharing, the Exchange will likely attract tens of thousands of individuals. This market power makes it incumbent upon the Exchange to establish a fair and transparent process in the selection of health carriers and health plans.

Federal law requires the Exchange to offer "qualified" health plans, and the Exchange will need to establish a selection process and evaluation criteria to solicit "qualified" plans from health carriers. Exchanges will have three ways in which they can approach this responsibility: 1) as a market organizer/distribution channel; 2) as a selective contracting agent; or 3) as an active purchaser.

Under the "market organizer/distribution channel" model, the Exchange would establish threshold criteria and offer all health carriers and health plans that meet the criteria. The Exchange acts as an impartial source of information on health plans that are available in the market; provides structure to the market to enable consumers to compare health plans based on relative actuarial value; administers premium subsidies; and serves as a broker of health insurance.

In the "selective contracting agent" model, the Exchange plays a more active role. The Exchange may attempt to exert its influence in the market and enhance competition by contracting with a limited number of carriers offering a select group of health plans, or by

requiring that health carriers and health plans meet certain cost and/or quality metrics. The Exchange might solicit plans based on plan design parameters or preferred plan types.

The Exchange, under the "active purchaser" model, establishes plan designs and purchases health insurance on behalf of its members, much like a large employer establishes and purchases health benefits on behalf of its employees.

Given the Exchange's role in the market and the availability of premium subsidies for low and moderate income individuals, carriers offered through the Exchange will likely have exclusive access to a sizeable population. This heightens the responsibility of the Exchange to establish a fair and open health carrier and health plan selection process, regardless of the decision to be a market organizer/distribution channel, selective contracting agent, or active purchaser.

Enrollment

Setting up a mechanism by which individuals and small employers can select a health plan and enroll in coverage is a primary purpose for the Exchange. How this is handled and by whom will be important decisions.

Individuals will be allowed to choose any health plan offered by the Exchange, while employees of small employers that purchase coverage through the Exchange may be limited to a level or tier of plans selected by their employer.

The ability of employees to "buy up" or "buy down" and the manner by which this selection process is structured will be of particular interest and concern to the health insurers whose products are offered through the Exchange. In almost all small group markets, carriers do not allow employers to offer their employees more than one, or possibly two, health plans from which to choose. More importantly, carriers typically do not allow another carrier's plans to be offered to a small employer.

These carrier underwriting rules are used to minimize risk selection. Placing all employees in one benefit plan eliminates the chance that individual employees will choose a plan based on their health status and/or the health care needs of family members.

However, restricting employees' health plan choices runs counter to what many people consider the central purpose and value of the Exchange for small employers; that is, allowing employees to choose the health insurance that best meets their needs. Some of the risk selection problems will be addressed by the establishment of risk corridors and the risk adjustment mechanism that will apply in the small group market. Nonetheless, Exchange administrators and state policymakers will want to carefully monitor the coverage choices of small employers' employees that purchase coverage through the Exchange, particularly if these employees are allowed to select from any of the four coverage tiers available in the small group market (i.e., Platinum, Gold, Silver, Bronze).

For individuals at or below 400 percent FPL, the premium subsidy for the individual consumer is based on the cost of the second lowest priced Silver level plan. Individuals

opting for a different plan may pay more or less premium, depending on their plan choice. The federal government will be providing a "defined contribution" that an individual may then take with him/her to shop for insurance.

Individuals will likely have a number of carriers and plans from which to choose. However, reduced cost sharing for lower-income individuals (i.e., those with income at or below 400 percent FPL) will only apply if the individual selects a Silver level plan. This provision of the law will likely limit the number of subsidy-eligible consumers who decide to purchase a Gold or Platinum level plan.

The Exchange could be structured to serve primarily as a conduit, providing people with information about their health plan choices, calculating health plan premiums – including the subsidy levels that may be available – and sending consumers to the health carriers to complete enrollment. The carriers would be responsible for enrolling the individuals, handling premium billing and collection, and providing customer service.

Under this scenario, the health carrier would be provided information from the Exchange with regard to the premium subsidy available to the individual. The carrier would need to coordinate with the federal government to collect any advanced tax credits and then bill the member for his/her share of the premium.

While the Exchange will serve as a single point of access for health coverage, federal law dictates that health insurers, and not the Exchange, will be responsible for billing and collecting premiums, as well as coordinating with the federal government for the advance payment of tax credits for subsidy-eligible individuals. Given the number of carriers and health plans that may be offered through the Exchange and the volume of subsidy-eligible individuals purchasing coverage, the complexity of each health carrier coordinating the billing process and aggregating premiums for hundreds of thousands of individuals with different subsidy levels may add significantly to the operational responsibilities of health carriers participating in the Exchange and may undermine the goal of reducing administrative costs.

The "Free Choice Vouchers" program may add another layer of complexity. Under this provision of the law, employees who are offered employer-sponsored insurance but whose share of the premium exceeds eight percent of their income may be eligible to use their employer's premium contribution to offset the cost of insurance purchased through the Exchange. In contrast to other provisions of the law, the Exchange is responsible for collecting the employer's share of the premium and applying this payment to the premium of the health plan in which the employee is enrolled.

For employers, the need for the Exchange to administer premium billing, collection, and remittance will be particularly crucial. Under the Exchange SHOP model, employees will be able to choose coverage from a number of carriers, depending on how the small employer program is structured. If the health plans are responsible for premium billing and collection, an employer purchasing coverage through the Exchange would need to pay

multiple health carriers for his/her employees, and would need to establish contractual relationships with the different carriers selected by his/her employees.

From an employer's perspective, the prospect of dealing with multiple insurers will greatly diminish the value of purchasing coverage through the Exchange. In addition to receiving multiple invoices and issuing multiple checks for his/her employees' health coverage, by not centralizing the premium billing and other administrative functions within the Exchange, the employer would need to deal with various carriers to handle mid-year changes in employment, changes in status for existing employees, and all of the other administrative tasks that are now handled through one health carrier or through a broker.

In light of those administrative challenges, the Exchange may be the more appropriate entity to assume responsibility for premium billing, collection, and remittance to the carriers, as well as other mid-year administrative tasks, such as changes in enrollment, COBRA notification, etc. In some states, health carriers already utilize intermediaries or third-party administrators to handle virtually all of these administrative tasks for individuals and small groups.

The Exchange is also responsible for establishing a process to determine whether an individual is exempt from the "individual responsibility penalty" (i.e., individual mandate) based on affordability or hardship. Information on each individual that is issued a certificate of exemption from the Exchange must be transferred to the secretary of the Treasury. Setting up a means by which individuals will be able to request an exemption from the mandate will be another core responsibility of the Exchange.

Current Infrastructure

The level of upfront investment and ongoing funding to support the Exchange will depend, in part, on the types of services currently being provided in the market and the extent to which existing infrastructure and resources may be leveraged and utilized by the Exchange. Regardless of whether the infrastructure and other resource needs are built or bought, there will be significant back-office infrastructure needed to set up the Exchange and service consumers.

The decision of whether and how best to utilize the services of private sector intermediaries will be affected by the capabilities of these businesses. Exchange administrators will need to determine which services can be handled internally, which should be outsourced, and which intermediaries may be best equipped to provide the administrative services required.

Administrative Efficiencies

Federal health reform should be viewed as an opportunity for Illinois to review its existing publicly subsidized health insurance programs, with an eye toward examining whether and how existing programs may fit into the changing marketplace given the availability of premium subsidies through the Exchange. In particular, Illinois should review public programs that provide premium subsidies for lower income individuals who work for small employers; programs that are designed to assist people who are recently unemployed (e.g., COBRA premium subsidy programs); and other programs geared toward helping working adults obtain coverage.

In addition, not only will it be important to understand the eligibility rules for the various public subsidy programs, but it will be critical to recognize how premium subsidies and benefits (e.g., what's covered and the cost sharing requirements) for similarly-situated individuals might compare across these programs. For example, programs that subsidize employer-sponsored insurance offered by small employers will need to be matched against an Exchange-based program that provides subsidies for the purchase of individual insurance, as these programs will likely target many of the same people. We need to understand how the various programs interact and may need to restructure the programs so that they are complementary.

There may also be opportunities to consolidate, restructure, and/or streamline program administration. Given the requirement that states are expected to establish single portals through which eligibility for all public subsidy programs will be determined, states may have an added incentive to limit the number of programs offered.

Going Forward

Illinois will need to make a number of key decisions in the coming months to establish the proper foundation upon which to build an effective and efficient health insurance Exchange. And, while the federal health care reform law sets parameters within which the Exchanges will need to operate, the law also provides some flexibility to allow states to develop Exchanges that best meet the needs of their residents and employers.

The successful development and operation of the Exchanges will likely determine whether the federal health care reform law can achieve its goals of improving access to health coverage, enhancing the value of health insurance, and moderating the cost of health care. Across the country, state governments will play the pivotal role in operating these Exchanges.

Certainly, an immediate and significant challenge for us will be the development of a single, streamlined eligibility process to determine eligibility for Medicaid, CHIP, the Exchange, and other state health insurance programs. For Illinois, establishing a single eligibility

engine will either require an upgrade to existing eligibility systems or the development of a new eligibility system. Given the time and resources required to plan, design and develop eligibility systems, we will need to begin work on this requirement immediately in order to meet the January 2014 effective date.

Setting the rules for health insurers to participate in the Exchange, providing consumers with relevant and useful information to help them make informed decisions, streamlining administrative processes, and shifting the insurance market from one based on avoiding risk to one based on price and quality will require collaboration between Illinois and the federal government, across state agencies, and throughout the health insurance industry.

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